

(1) *Coverage.* A description of the coverage to be provided under the plan, including any supplemental coverage and the deductible and other cost sharing.

(2) *Actuarial value of bid components.* The applicant must provide the following information on bid components, as well as actuarial certification that the values are calculated according to CMS guidelines on actuarial valuation, including adjustment for the effect that providing alternative prescription drug coverage (rather than defined standard prescription drug coverage) has on drug utilization, if applicable.

(i) The actuarial value of the qualified prescription drug coverage to be offered under each plan for a Part D eligible individual with a national average risk profile for the factors described in § 423.329(b)(1) and the basis for the estimate.

(ii) The portion of the bid attributable to basic prescription drug coverage and the portion (if any) attributable to supplemental benefits.

(iii) The assumptions regarding reinsurance amounts payable under § 423.329(c) used in calculating the bid.

(iv) The assumptions regarding low-income cost-sharing payable under § 423.329(d) used in calculating the bid.

(v) The amount of administrative costs and return on investment or profit included in the bid.

(3) *Service area.* A description of the service area of the plan.

(4) *Level of risk assumed.* For a potential Part D sponsor, the level of risk assumed in the bid specified in paragraph (e) of this section.

(5) *Plan Average Risk Score.* An estimate of the plan's average prescription drug risk score (as established under § 423.329(b)) for all projected enrollees for purposes of risk adjusting any supplemental premium.

(6) *Additional information.* Additional information CMS requests to support bid amounts and facilitate negotiation.

(e) *Special rule for PDP sponsors.* Bids for all plans offered by a potential PDP sponsor in a region, but not those of potential MA organizations offering MA-PD plans, PACE organizations offering PACE plans including qualified prescription drug coverage, and cost-based HMOs or CMPs offering section 1876 cost plans including qualified pre-

scription drug coverage, may include a uniform modification of the amount of risk assumed (based on a process to be specified) as described in one or more of the following paragraphs. Any such modification applies to all plans offered by the PDP sponsor in a PDP region.

(1) *Increase in Federal percentage assumed in initial risk corridor.* An equal percentage point increase in the percents applied for costs between the first and second threshold limits under § 423.336(b)(2)(i) and (b)(2)(ii)(A) and § 423.336 (b)(3)(i) and (b)(3)(ii)(A). This provision does not affect the application of a higher percentage for plans in 2006 or 2007 under § 423.336(b)(2)(iii).

(2) *Increase in Federal percentage assumed in second risk corridor.* An equal percentage point increase in the percents applied for costs above the second threshold upper limit or below the second threshold upper limit under paragraphs § 423.336(b)(2)(ii)(B) and (b)(3)(ii)(B).

(3) *Decrease in size of risk corridors.* A decrease in the size of the risk corridors by means of reductions in the threshold risk percentages specified in § 423.336(a)(2)(ii)(A) and/or (a)(2)(ii)(B).

(f) *Special rule for fallback prescription drug plans.* Fallback prescription drug plan bids are not subject to the rules in this section. They must follow requirements specified in § 423.863.

[70 FR 4525, Jan. 28, 2005, as amended at 75 FR 19818, Apr. 15, 2010; 76 FR 21573, Apr. 15, 2011]

§ 423.272 Review and negotiation of bid and approval of plans submitted by potential Part D sponsors.

(a) *Review and negotiation regarding information, terms and conditions.* CMS reviews the information filed under § 423.265(c) in order to conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan. In addition to its general negotiating authority under section 1860D–11(d)(2)(A) of the Act, CMS has authority similar to that of the Director of the Office of Personnel Management for health benefit plans under Chapter 89 of title 5, U.S.C.

(b) *Approval of proposed plans.* CMS approves the Part D plan only if the

plan and the Part D sponsor offering the plan comply with all applicable CMS Part D requirements, including those related to the provision of qualified prescription drug coverage and actuarial determinations.

(1) *Application of revenue requirements standard.* CMS approves a bid submitted under § 423.265 only if it determines that the portions of the bid attributable to basic and supplemental prescription drug coverage are supported by the actuarial bases provided and reasonably and equitably reflect the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for benefits provided under that plan, less the sum (determined on a monthly per capita basis) of the actuarial value of the re-insurance payments under § 423.329(c).

(2) *Plan design.* (i) CMS does not approve a bid if it finds that the design of the plan and its benefits (including any formulary and tiered formulary structure) or its utilization management program are likely to substantially discourage enrollment by certain Part D eligible individuals under the plan.

(ii) If the design of the categories and classes within a formulary is consistent with the model guidelines (if any) established by the United States Pharmacopeia, the formulary categories and classes alone will not be found to discourage enrollment.

(iii) A plan that adopts the categories and classes discussed in paragraph (b)(2)(ii) of this section may nevertheless be found to discourage enrollment because it excludes specific drugs from the formulary.

(3) *Substantial differences between bids—(i) General.* CMS approves a bid only if it finds that the benefit package or plan costs represented by that bid are substantially different as provided under § 423.265(b)(2) of this subpart from the benefit package or plan costs represented by another bid submitted by the same Part D sponsor.

(ii) *Transition period for PDP sponsors with new acquisitions.* After a 2-year transition period, as determined by CMS, CMS approves a bid offered by a PDP sponsor (or by a parent organization to that PDP sponsor) that recently purchased (or otherwise acquired or merged with) another Part D

sponsor if it finds that the benefit package or plan costs represented by that bid are substantially different from any benefit package or plan costs represented by another bid submitted by the same Part D sponsor (or parent organization to that Part D sponsor).

(4) CMS may decline to approve a bid if the Part D sponsor proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(c) *Limited risk plans.* (1) Application of limited risk plans. There is no limit on the number of full risk plans that CMS approves under paragraph (b) of this section. CMS approves a limited risk plan in accordance with paragraphs (c)(2) and (c)(3) of this section only if the access requirements under § 423.859 are not otherwise met for a PDP region.

(2) *Maximizing assumption of risk.* CMS gives priority in approval for those limited risk plans bearing the highest level of risk, but may take into account the level of the bids submitted by the plans and is not required to accept the limited risk plan with the highest assumption of risk. In no case does CMS approve a limited risk plan under which the modification of risk level provides for no (or a minimal) level of financial risk.

(3) *Limited exercise of authority.* CMS approves only the minimum number of limited risk plans needed to meet the access requirements.

(d) *Special rules for private fee-for-service (PFFS) plans that offer prescription drug coverage.* PFFS plans (as defined at § 422.4(a)(3)) choosing to offer prescription drug coverage are subject to all MA-PD bid submission and approval requirements applicable to MA-PD plans with the following exceptions:

(1) *Exemption from negotiations.* These plans are exempt from the review and negotiation process in paragraph (a) of this section, and are not held to the revenue requirements standard in paragraph (b)(1) of this section.

(2) *Requirements regarding negotiated prices.* These plans are not required to provide access to negotiated prices. However, if they do, they must meet the applicable requirements of § 423.104(h).

(3) *Modification of pharmacy access standard and disclosure requirement.* If the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost sharing and without regard to whether they are network pharmacies, §§ 423.120(a) and 423.132 requiring certain network access standards and the disclosure of the availability of lower cost bioequivalent generic drugs does not apply to the plan.

(e) *Special rule for plans with standardized bids sufficiently below the national average monthly bid to result in a negative premium.* In the event of a negative premium, as described in § 423.286(d)(1), CMS negotiates the incorporation of the negative premium amount into the bid as either a reduction in the supplemental premium if the Part D plan already submitted a bid with an enhanced alternative benefit, or CMS requires the addition of new enhanced alternative benefit of no less value than the amount of the negative premium.

[70 FR 4525, Jan. 28, 2005, as amended at 75 FR 19819, Apr. 15, 2010; 76 FR 21574, Apr. 15, 2011]

§ 423.279 National average monthly bid amount.

(a) *Bids included.* For each year (beginning with 2006) CMS computes a national average monthly bid amount from approved bids submitted under § 423.265 in order to calculate the base beneficiary premium, as provided in § 423.286(c). The national average monthly bid amount is equal to a weighted average of the standardized bid amounts for each prescription drug plan (not including fallbacks) and for each MA-PD plan described in section 1851(a)(2)(A)(i) of the Act. The calculation does not include bids submitted by MSA plans, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act.

(b) *Calculation of weighted average.* (1) The national average monthly bid amount is a weighted average, with the weight for each plan equal to a percentage with the numerator equal to the number of Part D eligible individuals enrolled in the plan in the ref-

erence month (as defined in § 422.258(c)(1) of this chapter) and the denominator equal to the total number of Part D eligible individuals enrolled in a reference month in all Part D plans except MSA plans, fallbacks, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act.

(2) For purposes of calculating the monthly national average monthly bid amount for 2006, CMS assigns equal weighting to PDP sponsors (other than fallback entities) and assigns MA-PD plans included in the national average bid a weight based on prior enrollment (new MA-PD plans are assigned zero weight).

(c) *Geographic adjustment.* (1) Upon the development of an appropriate methodology, the national average monthly bid amount for Part D plans will be adjusted to take into account differences in prices for Part D drugs among PDP regions.

(2) CMS does not apply any geographic adjustments if CMS determines that price variations among PDP regions are negligible.

(3) CMS applies any geographic adjustment in a budget neutral manner so as to not result in a change in the aggregate payments that may have been made if CMS had not applied an adjustment.

(4) CMS does not apply any geographic adjustment until an appropriate methodology is developed.

§ 423.286 Rules regarding premiums.

(a) *General rule.* Except as provided in paragraphs (d)(3), (d)(4), and (e) of this section, and with regard to employer group waivers, the monthly beneficiary premium for a Part D plan in a PDP region is the same for all Part D eligible individuals enrolled in the plan. The monthly beneficiary premium for a Part D plan is the base beneficiary premium, as determined in paragraph (c) of this section, adjusted as described in paragraph (d) of this section for the difference between the bid and the national average monthly bid amount, any supplemental benefits and for any late enrollment penalties.